would come to the center and be part of both the admission process, but also the discharge process. In a lot of the other services it seemed as though the warriors were on their own.

And I'm curious whether or not there's any data that says, you know, if we could remediate some of this before it becomes a problem by giving proper training, by making sure that it's a holistic thing, maybe the tail-end wouldn't be as big.

DR. CARRIQUIRY: You know, this is another very interesting point. So, talking about the stigma, many of the things, many of the veterans report that they hesitate to seek care because they go to their superior and their superior says, "Man up." You know, "Don't be a wimp."

And so that's one of -- I'm not saying that this is everywhere, but we have heard reports from veterans that say, "I don't get support from my superiors to seek mental

healthcare."

So that's another one. I'm not sure about the resilience training. I don't really know how to answer that question.

DR. KHAN: If I may add, to the Marine Corps side of the house. My son served for five years. He came back from Afghanistan. He was a different individual altogether. And that was about seven years ago.

At that time, prior to discharge, he was in San Diego. For six months he had to go through becoming a civilian. And they pounded on him, pounded on him that you have to seek. On top of it, me being a combat veteran, I made sure that he was prepared to come home. And I knew he was not. However, the system took care of him.

DR. CARRIQUIRY: Yes. So, your son had the benefit of having a supportive family. This is one of the biggest facilitators to seeking and keeping mental healthcare among veterans.

There are a lot of veterans that do receive this type of support from their community, the service, or what have you. But the vast majority of them don't. I shouldn't say the vast majority of them. There's a sizeable proportion of veterans that fall through the cracks between DoD and VA.

So they become civilians and they don't know how to reenter, you know, how to get into the VA system. I think that's a big thing to address.

CHAIR LEINENKUGEL: Alicia, real quick. And I'm going turn it over to Wayne. Just so I don't forget Wayne that's a -- I'm on Medicare now.

You talked about underperforming VAs. Is that data available for a who, when, where and why they were underperforming? You must have a list some place.

DR. CARRIQUIRY: Yes. We don't have a list, but the VA does. So, one of the things that we did as a committee was, after each site

visit, we wrote a report. We didn't write a report that said this clinician is a disaster. We wrote a report that said, you know, we have found these issues in this facility and these things could be improved. And so on and so forth.

And so those reports, they were pretty short, three or four pages each, were submitted to VA by the contractor, not by us. Not by the Committee, but by Westat, who was the contractor that worked with the Committee. So they exist.

CHAIR LEINENKUGEL: My question is, I'm looking around at people that support us. Can we find access to that? We need to start building some quantitative data points here.

DR. CARRIQUIRY: So the people that you should contact, my staff, so, Laura and Abby. They would -- yeah.

(Off-microphone comments.)

CHAIR LEINENKUGEL: Okay. Last follow-up and then Wayne. What were the main

reasons that your group of individuals found that veterans said we're getting great mental healthcare or we're getting adequate mental healthcare? What were the main drivers? Was it the type of therapy? Was it the drug therapy? Was it the counseling?

DR. CARRIQUIRY: It was really interesting. They complained about the types of therapy. They complained about the access. They complained about many other things. Yet, they rated the VA care very highly.

I think it was a combination of they felt comfortable in this environment that was sort of familiar with them. They felt that the professionals who were frazzled and overworked were still caring and were very capable. They felt that the quality of the care they received was very high, even though they wanted more of it.

And so it was a combination. I think that it's a love/hate relationship I think that the veterans have with the VA.

CHAIR LEINENKUGEL: Yeah. That's fair enough.

DR. JONAS: I'll just add one more data access issue. And perhaps this is it. You know, we're going to be asked, and have been asked, to look at preferences and experiences in those areas. And I imagine you have some of that data. So, it might be good to actually see if we can get some of that information.

DR. CARRIQUIRY: Yes.

DR. JONAS: Because that may be a source. I'll just, you know, add onto that. Because that's not easy to get. And it sounds like you did a very thorough assessment of what was going on.

(Simultaneous speaking.)

DR. JONAS: So it would be really great to look at that. And I'll look through the report and if there are back reports that get into that.

I'm interested in if you looked at

the flip side of stigma. Which is the disability system.

DR. CARRIQUIRY: The what, sir?

DR. JONAS: Disability system. Because mental health disability is something that is available now. I see patients in the military. Mostly active duty. And many of them are getting ready to get out. And some of them have had a few years. Some of them have had, you know, they're getting up towards retirement age.

And so I have conversations with almost all of them about what their goals are, what their purpose is in coming and in getting therapy. And some of them, even though there's clear evidence-based approaches that could help them get better, don't have those goals, because they're about to get out and they want to make sure that their benefits are not impaired.

Can you talk a little bit about that?

DR. CARRIQUIRY: Oh, yeah. So that was another big reason for veterans maybe to come in the door, but then not continue with the treatment, because they didn't want to be cured. Because if they were cured, you know, or graduate, I don't know how you say this, because of the loss of benefits.

So many of them said, you know, sorry, I cannot continue coming, because if you say that I'm okay, I'm going to be losing this benefit, the other benefit, and the other benefit.

I don't know what the solution for that is, to be honest with you. But, yes, there was a very large number of veterans that said that. Yeah.

DR. JONAS: I guess the other thing, too, I would love to have some assessment of how to better organize. I think there are, what, 20,000 organizations in the country that are here to help veterans.

DR. CARRIQUIRY: Yeah.

DR. JONAS: How many? Fifty thousand?

DR. CARRIQUIRY: I have no idea. But --

(Off-microphone comments.)

DR. JONAS: Forty-five thousand. That's right Okay, sorry. There's a boatload.

DR. CARRIQUIRY: There's a boat load of them, yeah.

DR. JONAS: Forty-thousand coded. Coded, but nobody really knows. I mean, talk about sitting on a ham sandwich while we're starving. If we could somehow help manage that in a way that assured quality.

DR. CARRIQUIRY: Yeah.

DR. JONAS: They're in the communities. I mean, and this is community access. So you have a whole thing on, you know, how do we get community interface in those areas?

And I'm just wondering if there's some low-hanging fruit in that area. Is there a map of

how to do it so that these ICTs, once they get in and now are helping, can actually get that?

DR. CARRIQUIRY: You know, I don't know if there's a map. But if I was in charge of doing that, the first thing I would do is go to the Vet Centers. People forget that the Vet Centers are part of the VA. They think of the Vet Centers as something else.

The Vet Centers are the most effective means to attract veterans to the VA. They are typically staffed by veterans. Occasionally they have a clinician, but not always. There's providers there that know how to direct the traffic and tell the veterans to go here or there.

And those are also people that know the lay of the land in their community. So I think the Vet Centers is the nucleus. This is the center from which you then can expand elsewhere.

MR. ROSE: I think just another comment there. Another comment, and that is, I

don't care if it's a substance abuse problem or if it's a mental health issue. And you look at the spectrum and how a person goes through that.

And you start out with the dark days. I mean, generally a lot of people may have to bottom out before they seek that help.

But the second critical step is acceptance of that problem before they go for treatment. And that, in many cases, is a difficult nut to crack. It really is. For whatever reason. Whether it be stigma, whether it be family, whether it be cultural.

But that's a huge piece. And I think it's very important. Because before you have that acceptance, you're not going to get the treatment. You're not going to go for coping. And you're not going to get on with your life. So I think we all have to be aware of that, too.

DR. CARRIQUIRY: That was one of the striking findings. Right? So, we screened

about 8,000 veterans using the usual screeners for substance abuse, PTSD, and depression, and all these other things. And among the ones that we screened and did appear -- this is not a diagnostic, obviously. It's just a screener.

But those that did appear to have a mental health thing, about half of them didn't even know it. And so, you know, that's about a million veterans if you expand out the numbers.

And that is a population that, you're absolutely correct, is going to be very difficult to reach because they are not seeking care.

CHAIR LEINENKUGEL: Anything else?

(No response.)

CHAIR LEINENKUGEL: Alicia, thank you so much for that. It was very helpful for us. And it gives us another perspective to work off of, and some more data points to collect. So thank you.

DR. CARRIQUIRY: Thank you so much. Good luck with your work. And if you need any

more information, you know where to find me.

CHAIR LEINENKUGEL: We will. Thank you very much.

(Applause.)

CHAIR LEINENKUGEL: With that, commissioners, I'd like to say that we got back on time. Thanks to, I think, Alicia. And no formalized bio-break.

(Laughter.)

CHAIR LEINENKUGEL: Also, this, in my opinion, wrapping up the day, this was a great day. This is an historic day from the seven of us in this U-shaped environment right now.

Our goal 18 months from now is to make historic recommendations for the improvement of veterans' mental healthcare throughout the VA.

And also, I think, a larger outcropping of that, seeing that this is now exposed on a national level, nationwide, with our general population, that once again, we'll

be taking the lead, and should be taking the lead, as far as making sure that at least our veteran subset of our general population is living up to the promise that various groups, including our whole health has put up on the screen today, that we have a commitment to our veterans.

And they also have a commitment back. And that is to, with the healthcare and the great clinical care that we provide them, that they get better. And we provide the tools for them to get better.

So, I'm just very proud to be part of this Commission. I thank you for being all in on day one. Day two is, again, going to be a very interesting day. We're going to have Fran present a lot tomorrow with the background that she has, and also give us a clearer direction. We're going to spend, then, the entire afternoon talking about our outcomes, how we're going to work together, what product we're going to actually produce,

how we're going to get there and work as, what I call a team, rather than just a generalized commission.

So I thank you. And one piece of administrative knowledge. We have a great place for dinner tonight. It's an historic place on a historic day. Why not? It's the Old Ebbitt Grill. It's the oldest bar, pub, eatery, I think, in D.C. And it's where a lot of legislation was either won or lost. And in most cases it was won, I think, over a beer or a gin martini, depending on the era.

(Laughter.)

CHAIR LEINENKUGEL: But it will be a great time there this evening, just to break bread with each of you and relax a little bit. And then we'll get on with day two tomorrow.

(Whereupon, the above-entitled matter went off the record at 4:51 p.m.)

X

Thomas (Jake) Leinenkugel
Chairman, COVER Commission

Comment [DK(]: Signature block is here

UNITED STATES DEPARTMENT OF VETERANS AFFAIRS

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CREATING OPTIONS FOR VETERANS'
EXPEDITED RECOVERY (COVER) COMMISSION

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CLOSED SESSION

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WEDNESDAY
JULY 25, 2018

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The Commission met in the South American A/B Room of the Capital Hilton, 1001 16th Street, Washington, D.C., at 1:36 p.m., Jake Leinenkugel, Chair, presiding.

PRESENT

JAKE LEINENKUGEL, Chair; Senior White House Advisor, Veterans Administration

THOMAS E. BEEMAN, Ph.D., Rear Admiral, U.S. Navy (Ret), Co-Chair; Executive in Residence, The University of Pennsylvania Health System

COLONEL MATTHEW F. AMIDON, USMCR, Director, Military Service Initiative, George W. Bush Institute

WAYNE JONAS, M.D., Executive Director, Samueli Integrative Health Programs

JAMIL S. KHAN, U.S. Marine Corps (Ret)

SHIRA MAGUEN, Ph.D., Mental Health Director of the OEF/OIF Integrated Care Clinic, San Francisco VA Medical Center

JOHN M. ROSE, Captain, U.S. Navy (Ret), Board Member, National Alliance on Mental Illness

ALSO PRESENT

SHEILA HICKMAN, Designated Federal Official
SHANNON BEATTIE, MPH, Senior Project Analyst, Sigma Health Consulting, LLC
LUIS CARRILLO, VHA Administrative Support
FERNANDA CARRION, Junior Project Analyst, Sigma Health Consulting, LLC
YESSENIA CASTILLO, Senior Consultant, Sigma Health Consulting, LLC
KRISTIANN DICKSON, VA Support Team Project Manager; Alternate DFO
BETH ENGILES, Senior Manager, Sigma Health Consulting, LLC
LAURA McMAHON, Contracting Officer Representative; Alternate DFO
FRANCES MURPHY, M.D., MPH, President and CEO, Sigma Health Consulting, LLC
STACEY POLLACK, Ph.D., Alternate DFO
ALISON WHITEHEAD, Alternate DFO

P-R-O-C-E-E-D-I-N-G-S

1:36 p.m.

CHAIR LEINENKUGEL: Did you need me to repeat all the gobbledygook that I said in the previous 60 seconds? So we're really going to discuss roles and responsibilities of all of us as a group. You just see what's laid out in the law and what the DFO has set up as far as operating principles for the Chairman and Co-Chairman. The DFO and certainly the ADFO can certainly see all of the work that they're responsible and accountable for and then the training that goes in for them even to be an assistant designated federal officer.

There's the alternate. Role and responsibility of commissioners, that's all of us. And I think that just getting to know all of you in the last 36 hours, there's not going to be an issue that I foresee or I think anybody here would foresee with this.

We are going to meet very few times

in 18 months, at least as scheduled. We may change that later today or by August.

Support staff. You've heard from the support staff, and I think there's going to be a lot of options that we haven't even thought about. But once we start doing the work, this is who we'll turn to through the DFO using chain of command and certainly have them get to the right parties.

Remember that there is budget, and we certainly had that available to us to use outside sources, to use consultants, to bring in subject matter experts that may have to pay for travel, etcetera, etcetera. So, I mean, it's not like we're running blind or naked here.

So there's going to be more than enough resources. And I think you've heard yesterday from the lead of VHA, Dr. Rich Stone, and you also heard from the acting secretary who spoke for the incoming Secretary Wilkie that this is a big deal, which it is, and that

it's going to be fully supported by the VA and the VA is responsible for the funding.

Oh, you've got to have one of these, right? That's why we're splitting right through it. Doesn't anybody want to go back and take a look at those? You can see the breakdown, just so you have some sort of idea of the flow of the Commission itself and some of the people behind the scenes, whether they're project analysts or contracting officers. This would be your go-to sheet, and what I would like, Sheila, is for, you know, this sheet would make sense for me to have at my desktop sometimes with telephone numbers, whether it's personal cell number and/or an email. So maybe that's an attached sheet to this one or right behind it.

I try to keep my paperwork -- I know it's in the binder. I try to keep my paperwork simple, so there's two sheets that I want: this and a contact sheet that I can put in my back pocket or in my suit jacket at all times.

This is where I want to stop and want everybody to have some input, if necessary. Again, I slept on this last night after a good meal, a couple of beers, some good conversation, and a full day. I think that we're going to be just fine with this, and there's nothing as far as things on here that you don't know either from personal practices, daily practices, who you are as individuals. But, you know, respect and fair treatment is just a good way to conduct ourselves daily in front of anybody, including our families, best friends, and even some people that we don't necessarily get along with but you still treat them with respect and dignity.

Objectivity. Base decisions on factual analysis. I always have a question with that because I don't know the facts, and I brought that up day one. And sometimes facts are, there's just too much of the unknown that are facts cover-up, and I don't know if you know what I'm saying by this but there's things

that we don't know that we should ask questions about as commissioners and not get fully inundated with, well, this is the fact-based evidence reason why.

So I love to challenge things. I want you to challenge things. But at the same time, don't allow bias or a conflict of interest or any undue influence, and I don't see that happening with this group either.

Address differences of opinion and handle them constructively and professionally. We've already seen that, and we've done it with this group. So, I mean, good commissioners should not all agree. The consensus group, getting to consensus, we'll talk about that.

Transparency is the only way to go, and I think that there's been nothing but respect for every speaker, even amongst ourselves, with the attentiveness that I've noticed from this group.

Operating principles. So now it's really about engagement, and we've had this.

So reflect on each one of these for a minute. Consider and debate a variety of alternatives supported by the factual analysis. And, again, when it says factual analysis, I'll push back on some people sometimes. And I'm not talking untruths here, but I'm saying that, ladies behind me, don't get me wrong, yes, everything is based on facts and from Sigma Group facts always rule the day. But at the same time, we have to have some sort of gray area that we're always going to debate and discuss.

So that leads to the second bullet point: contribute to debate in the identification of alternative recommendations. No one-on-one side meetings or conversations. Strive to meet the stated purpose and expected outcomes of the meeting and the Commission. I think that's our general charge.

Are there anything else from the good of the order of the commissioners that are missing up there? I didn't think so. Oh, there's one.

DR. BEEMAN: One thing on the first one, we have the commissioners, the staff, I might add "and guests" because we've had all friendly guests so far, but we might have somebody that disagrees with us and is bringing an alternate perspective, and I'm just thinking we might want to put "and guests" in number one. That one, where it says commissioners and support staff, I might put commissioners, support staff, and guests.

CHAIR LEINENKUGEL: So noted and a great point and a terrific addition. Agreed. Operating Procedures. Well, we're in the middle of the execution of the first one and how work will be conducted is really the biggest piece and the prize that we have to attack here before we leave this afternoon, and it's going to lead to decision-making and voting protocol at some point, so let's discuss those now, as well.

So the meeting agenda Sheila has put up well in advance, and I think everybody has

seen this and probably filled your calendars and looked for dates. The key here is that you have to be at least 60 days out, I believe. Sheila, is that correct?

MS. HICKMAN: About 90 days out for location.

CHAIR LEINENKUGEL: Ninety days out for location.

MS. HICKMAN: Thirty days out for Federal Register.

CHAIR LEINENKUGEL: Thirty days out for Federal Register. So there, you know, set dates that we have to be ahead of. And so right now, I would surmise that you are working on October, Sheila, you and your group. So the location needs to be determined by the Commission today; is that correct?

MS. HICKMAN: Yes it is.

CHAIR LEINENKUGEL: Okay. So let's think about that for a minute. I'm going to turn my mic off after I say let's try to come to a consensus. We'll see if we can get to the

next page on voting rights. Let's go there first. You've all seen this model. It's been in your handout. You've all lived it, you've all worked it before. Consensus is always the best way for any group to end up, and we need to always try to get consensus. As I told Sheila getting into this, there will probably be areas where we will not get to consensus, and we need to recognize that as commissioners and as a group and be comfortable with that.

So I will not give you my Jake Leinenkugel spiel on this. I want you all to chime in because this can play a big factor in how we go forward. Comments? Take a little bit to digest this.

COLONEL AMIDON: Having been on committee-based stuff before, we're always striving to achieve consensus, but just recognize that the majority rule will apply at certain times. And if you are not of the majority, perhaps you just state your objection for the record and move on.

CHAIR LEINENKUGEL: That's exactly it. I wish you were talking directly into the microphone. Were you able to get what Matt said for the record, even though it's your record? Thank you, thank you. Does everybody agree with what Matt, Commissioner Matt Amidon said? Anybody disagree?

(Off microphone comments.)

CHAIR LEINENKUGEL: Don't give us your minority opinion.

(Laughter.)

CHAIR LEINENKUGEL: Well, now it is important because there's going to be that time. And I think we all agree that the majority rule then will take place. Good.

Now, this is the work for the next however long it's going to take us, and that will be decided by all of us in here, but it's how we will conduct the work and assign the initial lead-in project breakdown based on tab, is it H of the COVER Commission? And everybody should have it memorized by now anyway. No,

I'm talking the COVER Commission. F? Thank you.

So prior to the start of this morning's open meeting, Tom Beeman and I spoke and I said my thinking at this time and, Tom, disagree or agree, but a quick way to at least establish a working protocol would be for you and I to take the five main performance and duties outcomes for the Comprehensive Addiction Recovery Act of 2016 and divide and conquer.

So Tom has agreed to be responsible for duties one, which is examine the efficacy of the evidence-based therapy model used by the secretary for treating mental health illnesses of Veterans and identify areas to improve well-based outcomes. Two is the lengthy one, but it involves the survey, so it's the whole list that we spent time on today with the survey and we know what issues are involved with that. And then three is examine the available research on complimentary and integration health treatment.

I originally took this, but I have some strong biases for some of these. And maybe that's not a bad thing, but I thought it just best at this point that Tom probably lead this process with a different perspective or without my bias at this point. So I took four and five.

And so what we would like to do is try to get some subgroups, and I'm calling them subgroups rather than subcommittees, and I think we need to get a clarification on terminology. So, again, let's think about this before we act, but a subcommittee, in my mind, is different than the members of this commission. Could I get a legal opinion on that?

The way I read it, and maybe I'm wrong, is that subcommittees can be assigned, we can bring people in, whether they're consultants, subject matter experts, advisors, world-renowned doctors, and assign them to a subcommittee to do a component of work outside

of the commissioners. And then they would take that work back and present it either to a subgroup of the Commission or to the entire Commission. That's the way I interpreted that.

MS. HICKMAN: And you're exactly right. So it's a pulling together of experts that become a subcommittee. So if you're working on surveys, then you would pull together some experts from around, wherever those experts would come from. We would not be able to pay them; just know that. But all they would do is completely work on that subject, and then they would report out to the group. They don't report out to anyone. They can't talk to Congress, they can't say what their recommendations are. They can't make decisions or votes like that, but they can present their recommendations to the group and the group can make decisions based on those recommendations.

CHAIR LEINENKUGEL: One of the few times that I was right when I interpreted something that I read out of this binder. So

that's correct.

MS. HICKMAN: And we can have several.

CHAIR LEINENKUGEL: Right. There can be multiple subcommittees. So just for the sake of not confusing ourselves, let's call our group workgroups, commissioner workgroup, and all of the other sub stuff that we have or bring in will be outside. Does that make it easier for everybody to understand it? So if there is going to be a subcommittee to the Commission, it can certainly be called, I would think, by either myself or at least Tom at this point, and if you have recommendations, we want the other commissioner recommendations of a particular type of people on it, there might be some individual, knowing people have resources that you have contacts with, and that's what we, as commissioners, should bring --

MS. HICKMAN: Sir, if I might say something. If we're going to split into those three or those six areas, five areas, it would

be better if we were to get any individuals that are on those groups and put it in writing and get it so that we can tell the secretary up-front we broke down into these subcommittees, even internal to the group here, and that way it --

CHAIR LEINENKUGEL: Workgroups.

MS. HICKMAN: And workgroups within the body of the letter, yes. But --

CHAIR LEINENKUGEL: For what --

MS. HICKMAN: It covers us because we're a Presidential Commission, everything that we do is subject to audit. So if we step outside of FACA rules and start using our own terminology or anything like that, then we could be suspect under the FACA rules. So everything --

CHAIR LEINENKUGEL: This is a good time to be going through this discussion. What is outside the FACA that I just --

MS. HICKMAN: So if we set the terminology as workgroups, there aren't

workgroups, there are subcommittee rules. And really all it does is protect us to have that in writing that says Jake and Wayne and Matt are a subcommittee that are looking at these three areas. It's protection for us to be so that, if we are audited, then that comes out and it says, no, we established it up-front that this group was responsible for these three areas.

CHAIR LEINENKUGEL: Okay. We're playing by the rules, so we will work within, everybody that will be assigned -- I still need clarification because now you're confusing me, again back to FACA. If you want me to call it, because of FACA rules, subcommittee, we will call it a subcommittee to meet the FACA rules.

MS. HICKMAN: That would be awesome.

CHAIR LEINENKUGEL: We are not really subcommittees.

COLONEL AMIDON: Verified down to the very functional level, subcommittee describes the functional work that supports a

committee. We've been delineated as such, we're doing it according to five work streams currently. A subcommittee could comprise external members and/or --

MS. HICKMAN: Oh, absolutely, absolutely.

COLONEL AMIDON: -- just standing committee --

MS. HICKMAN: Yes, yes.

CHAIR LEINENKUGEL: So if you, as a subcommittee, are working on the first one that Tom has or say you're going to work on a survey and it's you and Jamil, you could bring in whoever, unpaid, that you want to bring in as long as it's agreed to.

So everything that we do in formulating, according to Sheila now, in order to meet the FACA rules, with a subcommittee we should have the list of names and then any outsiders that we bring in that are dubbed a subcommittee, they should be presented to you prior to them being approved to sit on a

subcommittee. Who makes that final approval?

MS. HICKMAN: So you can make the decision on whatever your SMEs are that you want within a subcommittee, as long as, you know, they're not paid, so any of that. But then all I need to know is who those individuals are, basically a little bit about where they're located and everything like that, so I can put another memo together that says we've established a subcommittee that is completely looking at cannabis oil, period, and, you know, it would cover it.

What I don't want to have happen is at any time during this 18 months or after it GAO comes down and says you did something illegal, and everything is thrown out the door. So I would prefer to cover us in every respect that we can.

COLONEL AMIDON: So if we came up with an aggregate list of external candidates, independent of which subcommittee they're part of, do we need a census vote to approve to

outreach to all of them and then you do the outreach?

MS. HICKMAN: No. So if you decide who you want on your committee, Jake then is who you need to let know and me, of course. I mean --

COLONEL AMIDON: But we have the latitude to --

MS. HICKMAN: Yes, we're linked at the hip.

COLONEL AMIDON: And we're free to do outreach --

MS. HICKMAN: You can do outreach.

COLONEL AMIDON: -- clarity of the message --

MS. HICKMAN: So there's no -- subcommittees don't travel, so if you set a subcommittee up you travel to them. They meet at whatever location, but we're not paid travel or anything like that.

COLONEL AMIDON: Do you have a framework so that, you know, is this --

MS. HICKMAN: I can completely --

COLONEL AMIDON: Since it's endorsed by you, that would make --

MS. HICKMAN: Yes, yes.

DR. BEEMAN: Here's a thought that I've been thinking about, particularly since I got assigned number three, as well. What we forgot to say is I agreed when he said one and two, and then I was assigned by Jake number three.

Here's what I was thinking. I was thinking that the subcommittee should consist of, at least the subcommittee that I've been assigned, at least the two clinical people on the group but publish the time and date of the call so that any member of the Commission that wanted to listen in could so that there's transparency. And then --

MS. HICKMAN: That we'd need to get back with you on.

DR. BEEMAN: Okay. The second piece was that we have, what, a DFO and a permanent

member of the team would be either Dr. Murphy or her designee. And that would be it, I mean as far as the official subcommittee folks.

The second part would be that the SMEs would actually be invited to provide information, input, but wouldn't be constituted as a member of the subcommittee. That's kind of what I was thinking because it keeps it neater and cleaner. But I did want to see if I could have, like if this was something Jack would like to listen in but he wasn't on the committee, to publish that because why not be transparent to the members of the Commission?

MS. HICKMAN: Well, subcommittees report out to the Commission, but if we're going to start all in to listen to what's going on, then we start forming a quorum and a meeting. So we just have to be very careful about that. So if you --

DR. BEEMAN: Listen but not too hard, is that --

MS. HICKMAN: If you own number

three, then certainly we would be listening in on that because you're already on record as being the owner of that and this is your subcommittee or sub-subcommittee. So then you would be on record about it. But I don't want then that expanded to say, hey, Jack, you know, Shira, you guys want to call in and listen to this because, all of a sudden, we're forming a meeting and we have not gone on record as a meeting.

DR. BEEMAN: This is the simple made difficult.

MS. HICKMAN: But there will be, there will be, whenever you travel or whenever a subcommittee or anything, there is an AFO or a DFO that will be present for that. So, like, if you were going out to meet with your subcommittee and you needed to travel to that location, you know, Alison or Stacey or Kris, probably not Laura because she's going to have surgery on her feet so we're not going to make her travel, but you would have, you would have

one of us available. And the reason is is because their job is to still protect you from all other FACA rules, too.

DR. BEEMAN: But you don't have to travel to a spot. You can do it by phone?

MS. HICKMAN: Yes, with an ADFO or DFO on the phone.

(Laughter.)

CHAIR LEINENKUGEL: Jack, did you have something?

MR. ROSE: Yes. On these experts who call in, how much lead time will Sheila need before you know who we'd like to come in? How much lead time for an expert to come in and let you know?

MS. HICKMAN: To a subcommittee or --

MR. ROSE: Yeah. To a subcommittee.

MS. HICKMAN: I mean, if you're forming your subcommittee, then tell me how many individuals you're pulling on to it because you're not going to start your

subcommittee until you've determined who your committee members are.

MS. DICKSON: But the SME may just be more time given, you know, more time --

MS. HICKMAN: Just in one time, then just let us know.

MR. ROSE: Okay.

MS. HICKMAN: An ADFO or DFO is present at everything, and then every decision that's made, not decisions but everybody that comes on, you know --

MS. DICKSON: And we don't do transcriptions of those meetings, but we do need minutes done. So someone would be there to support you and taking minutes, as well.

MS. HICKMAN: And I know we added that in and we can provide that. It won't be the young lady that's sitting here today, but it will be somebody who sits in and takes minutes for that.

(Phone ringing.)

MS. HICKMAN: Where is that? It

will be -- a transcriptionist basically will call in to those types of meetings so that they can take the minutes.

CHAIR LEINENKUGEL: So there's a reason why subcommittees was put up on this chart to begin with, and that's why they're saying subcommittees. So does everybody have a better understanding as to what is going to be required of us? Certainly from utilizing the DFO or the ADFO to be available for each one of those meetings, even if it is a call.

MS. HICKMAN: And, Jake, what I can do is go back and we can put together, you know, some scenarios and kind of lay it out a little cleaner and provide that to everyone so that they know, I'm doing this, this, this is what I need, and that way --

CHAIR LEINENKUGEL: I think a one pager should do it.

MS. HICKMAN: Yeah.

CHAIR LEINENKUGEL: Just with the main bullet points. We get it.

MS. HICKMAN: Okay.

CHAIR LEINENKUGEL: Until someone trips up and forgets to call the DFO or ADFO.

MS. HICKMAN: And call us for any of that stuff. I mean, seriously, we want to make sure that --

CHAIR LEINENKUGEL: Let's stay on that same subject. So a personal call from, say, myself and say it's Tom just to coordinate things, I hope we don't need a DFO or an ADFO during that call.

MS. HICKMAN: No, it's only for you coordinate something that's going to happen at the next meeting or something like that or if you have a question. But no.

CHAIR LEINENKUGEL: Okay. And what if I have a recommendation for how or who I want to bring in to this subcommittee, even though I'm not a part of it?

MS. HICKMAN: If you're making any sort of decision, then a DFO must be present.

CHAIR LEINENKUGEL: Okay. Well, I'm

not making a decision, I'm making a recommendation.

(Simultaneous speaking.)

CHAIR LEINENKUGEL: So my point is, though, is though, that if that did happen he would have to contact you if he made a decision based on --

MS. HICKMAN: If that phone call was held, just one of us on the phone call. But no decision should be made outside of this group that have anything to do with the scope and focus of this group.

MR. ROSE: Wait a minute. If you're trying to do number one and you get your subcommittee and you come up with recommendations, that all has to go back?

MS. HICKMAN: The recommendations come to the group.

MR. ROSE: Come to the group.

MS. HICKMAN: Yes, yes.

MR. ROSE: Okay.

CHAIR LEINENKUGEL: That's good to

know.

DR. BEEMAN: A thought. I was hoping that what would happen is that, once the two groups are designated, that I could say I'd like to have a phone call with a call-in number set up before our next Commission meeting, and then what would happen is you would be able to assign the DFO and see if Dr. Murphy or whoever, a member of her team, would be available for that call, if that's appropriate to those three issues, that we would have the call and then at the next meeting of the Commission in August we would report out, and that would be a great time then for you and I to discuss publicly, like, your recommendations on who to have appointed because then we have the DFO and everything like that.

MS. HICKMAN: And your both subcommittees. So as you just described, your team is a subcommittee. They're going to have to go in writing as a subcommittee and you are coming up with recommendations and then, yes,

you would bring it back and report it out.

DR. BEEMAN: And that would be the best time then, I was thinking in August, if we already had a meeting and then we were informed by Dr. Murphy's team, we could come back then in August with some recommendations that, you know, we thought about the questionnaire and we think it should be, you know, just a small targeted qualitative questionnaire, so that this group could say, yes, we agree with that or not. Does that make sense?

MS. HICKMAN: It wouldn't be, it wouldn't be just does this group agree. It is --

DR. BEEMAN: No, I'm saying that, in August, it would be the entire Commission, because we would be able to report out what we came up with in our meeting that was held before the Commission meeting.

MS. HICKMAN: Yes, you would report out as that subcommittee and then, as a whole, you would still vote to say this is a decision

that we're --

DR. BEEMAN: Okay. Thanks.

CHAIR LEINENKUGEL: And a cautionary note, even though I like us getting into this situation, is that you're going to hear some things from folks that are coming in in August that are going to probably be relevant to your subcommittee. So by me getting out in front of it, you may have a subcommittee phone conversation with recommendations and then you may hear something in August, say from Lynda Davis or the Veteran experience officer and go, oh, I did not know we had those capabilities or those resources or those survey type of mechanisms. So I'm just trying to coach you we, at some point, have to bring in VSOs in the mix. And there's not just the big four or the big six as they're called. There's actually 35 groups, and they all get a vote for Veterans Day and Veterans Month and they're all here during Veterans Day and Veterans Month. That's the only time you see a lot of these groups,

and there's a lot of very active planning groups that Matt works with, and has worked with for some time now that probably have some resources, as well.

I'm just saying that I like our energy going forward prior to the August meeting. I'm not saying stop. I'm just saying that August may lend some more clarity to fill in a couple of gaps for the working group to work on.

MR. ROSE: On that, we can't do anything until we meet anyhow, right? I mean, he could come forth, that group, with a recommendation, but we wouldn't act on it until we met, right?

CHAIR LEINENKUGEL: That's correct, that's correct.

MS. HICKMAN: But the sooner I get the subcommittee uses on record the better. So, I mean, if you know how you're going to break out within the next couple of days, let me know. I'll prepare that memo and get it up

for the secretary's signature. And really all it does is it warns him that there are subgroups that are looking at this and they will be calling in SMEs basically and getting some advice. But the permanent subcommittee members, I do need them on there, too.

CHAIR LEINENKUGEL: It's been very helpful, at least from the subcommittees --

MS. ENGILES: I think it will clarify the commissioner meeting. I just wanted to tell -- the way the Commission on Care operated is we set up subcommittees, we had a couple of commissioners on each committee, also had VA and support staff supporting those committees. Then those committees had a conference call every week that the staff set up. You know, the head of the committee set up the agenda, and they would call in and they said, you know, we really need to talk to Tracy Gaudet about, you know, something related to home health, attend that call, and then that subcommittee would pull

together all the information they learned, you know, between the previous meeting and then the next meeting and then they would present out this is what we've done since the last meeting, if they have any recommendations at this point, these are recommendations, we'll put it to the full Commission, and then the full Commission would make a decision about going forward.

MR. ROSE: Okay. That's good.

CHAIR LEINENKUGEL: How many commissioners were on that again?

MS. ENGILES: Fifteen. A much larger group.

DR. KHAN: So if I may ask a simple question. If I'm conducting patient-centered networks, at least I can do it two networks during that 30 days because each network, they have their own it's always done. That information would be available to us. Whatever is not available, I'm thinking of the 30-day time frame, you know. If we can achieve something during the 30 days and still prepare,

you know, what more is given to us.

CHAIR LEINENKUGEL: We're missing a person, as you know, right now who's not at this meeting. I forgot what title, Sheila, we're going to have Casin.

MS. HICKMAN: Chief Advisor.

CHAIR LEINENKUGEL: Chief Advisor. Casin Spiro who I think the world of, I think I talked to some of you about Casin, and maybe some of you have interacted with Casin. Casin will go through any barrier, any wall, any hurdle in a very short amount of time and get to the answer. So he would be the person that I see working directly with Sheila and myself to get through any issues that you may have with subcommittees or any of your personal ideas or approaches or questions. I call him Radar, if you remember M*A*S*H, and he's a 30-year-old that's going on 50. I thought he was going to be here today, but I know there's just way too much going on over at the VA. But know when he gets in here by the August meeting and

he'll be working with Sheila probably starting in the next couple of weeks, but he will at least transition in the next 30 to 60 days.

MS. HICKMAN: Thirty to 60 days, the only difference is that Casin can't touch FACA in his role, so anything that's FACA related has to come through here. Anything that -- like, Casin will help put together, like, SMEs, knowledgeable people that he is aware of throughout the community that he works with, and that's where he has a strength that he can bring in some of those additional people. Wouldn't you say that's right, Jake?

CHAIR LEINENKUGEL: I would. And I would also add that he will be able to work directly with the Chief of Staff of VHA, Larry Connell, who was just named Monday, working directly for Dr. Stone. So Dr. Stone you all met. Again, he will uphold everything that we want to do based on, I think, the incoming secretary once you've heard from the acting secretary today. So from that end, I think

you're going to see a sense of urgency, plus a sense to cut through what I call the layers to get better action.

So let me give you an example with the VISNs and everything you saw. Casin will be able to go much faster than anybody else in VHA if I were to call them in my previous role. He'll probably have the answer in the same day where I can tell you the way the old VHA worked, it would be three to five business days or you would be completely ignored. It's just the way the place operated. Sorry about that, Doctor, but that's VACO. VACO siloed VHA.

MS. HICKMAN: It is VACO.

CHAIR LEINENEKUGEL: Correct?

MS. HICKMAN: Yes.

CHAIR LEINENKUGEL: So that will change. That will take a 60-day period, and a lot of people are going to be nervous, rightfully so. There will be a huge sense of urgency to respond immediately back to cut through the layers.

So when you're talking about VISNs and getting to medical center directors, I think we're going to see immediate responses if we want to do site visits, if we want subject matter experts, if we need additional clinicians. Your counterparts, you know, many of them were in front of us the last day and a half. But they're wonderful people, and I think they're waiting to contribute.

So I'm excited because Casin is the Radar-type person that will hopefully navigate a lot of that while Sheila working along with the other AFDOs to make sure that we're playing by the FACA rules, right? Casin doesn't have to worry about so much. He just goes out and gets this stuff that we need to get done or bring the people in or bring the groups in. For instance, VSOs. He'll probably work directly with our VSO Rep, Jason Beardsley, and work with the White House Rep, Jennifer Korn, and activate what we need from key VSOs all within 24 hours.

MS. HICKMAN: And bring you a key speaker in that has subject matter experts, you know, for the committee or not the committee but the subcommittee meetings.

CHAIR LEINENKUGEL: So thanks for bringing that up because I forgot about Casin for a minute, but he's going to be a huge asset and resource that we can lean on a little bit. So I wish he was here right now. So both of us are a little apprehensive of how to break up the work right now.

DR. BEEMAN: Yes, that's why I have this sense of urgency about having a phone call before, even if it's just to tee it up with the committee.

CHAIR LEINENKUGEL: And I want you to do that. I think you should. I think the more that we interact together, even if it's not to the last step, okay? So what you're doing is you're going through one, two, three, and four, but getting to four subcommittees, develop recommendations, and present to the

core Commission. You may just bring back three recommendations or you may bring back six recommendations, and then we get to the last one at the August meeting. At the open meeting, we deliberate, modify, and develop alternate recommendations or accept your recommendations. Right? I'm looking for a consensus.

MS. DICKSON: I mean it may take more than one phone call to come up with a recommendation. It may take a phone call every week, you know. Give you time to think through it, talk through it, figure out what direction you want to take, and then come up with some recommendations. However many phone calls you need during that time, we can set them up.

MS. HICKMAN: You two can talk anytime. It's not, I mean, really it's just, you know, because you're the Chair and Co-Chair, you're not going to make decisions. But if you want to call Jake and say, ugh I can't deal with that you're taking --

(Laughter.)

CHAIR LEINENKUGEL: Take three back.

(Laughter.)

DR. BEEMAN: One of the things, I think, Jake, that would be helpful for me would be I would like, for sure, to have the two clinical people and then anybody else who would like to serve for those first three. But as I looked at them, I felt that one, two, and three, particularly with a list of things, required somebody with some clinical knowledge. And regrettably for them, they're the two that have the clinical knowledge. But if there's somebody else that says, yes, but I'm interested in that, that's great. But I'm afraid that if you and I met about this, it would be interesting but we wouldn't have --

CHAIR LEINENKUGEL: And as I said to you early on, I would definitely choose the two that you have on this commission --

DR. BEEMAN: Sure. And then if somebody else --

CHAIR LEINENKUGEL: -- and then I would probably say to Tracy Gaudet, either Tracy herself or somebody in Tracy's group. I mean talk about the people, and one of them happens to be an ADFO.

MS. HICKMAN: And I was just going to say you're in her area, and Alison is an ADFO, we put her as part of the --

DR. BEEMAN: Kind of both.

MS. HICKMAN: -- and she's the ADFO to that respective committee.

DR. BEEMAN: Sure.

MS. WHITEHEAD: And if there's a need for additional, you know, some work in my office, whether that's Tracy or -- we have additional SMEs.

DR. BEEMAN: Sounds good.

MS. HICKMAN: Yeah, that becomes very easy. But, yes, and then we just we got to take notes.

DR. BEEMAN: I'm in. You know, I have your email, so I'm going to have to send

it to you, Sheila, to help, you know, get people's phone numbers and all that kind of stuff.

MS. HICKMAN: Absolutely.

CHAIR LEINENKUGEL: Let's discuss emails. What are the FACA rules with emails?

MS. HICKMAN: I have not seen any FACA rules on emails, but don't make any decisions on email.

DR. BEEMAN: Well, you can have a decision to have a committee meeting, right?

MS. HICKMAN: If it's a meeting and we have informally announced a meeting, it has to be open and then we can't make those decisions on a phone call.

DR. BEEMAN: But subcommittee meetings don't have to be open?

MS. HICKMAN: Subcommittees are not subject to that. They're subject to minutes because of the presidential and an ADFO.

DR. BEEMAN: Okay.

CHAIR LEINENKUGEL: So are emails on

a government server dealing with this commission FOIA?

MS. HICKMAN: Yes.

CHAIR LEINENKUGEL: And are emails on personal laptops or personal iPADs FOIA?

MS. HICKMAN: I've never seen them go after a personal. I think they can tell you that they want to look at your personal, but you don't have to. A statement from OIG is that they do come after your personal, but you don't have to oblige them, you just have to tell them I don't have anything. Now, I would hope you don't. But, yes, everything that's in writing, every email I sent out to all of you guys to give you updates on everything, all of that is FOIA-able and auditable.

CHAIR LEINENKUGEL: Is it allowable for email then to be another avenue as far as working with a subcommittee rather than or in addition to telephonically? So in other words, you just finished a telephonic meeting and you just came up with another good idea and

thought. Can you go back to the subcommittee with an email and say, hey, here's another idea that I have?

MS. HICKMAN: Yes, because that's your subcommittee, yes. The ADFO or the DFO is always on any meeting. Always.

CHAIR LEINENKUGEL: Tom, did you get that?

DR. BEEMAN: I did not.

CHAIR LEINENKUGEL: Yes, I missed that, too. Wayne asked the question do you have to go back to the DFO or ADFO an email recommendation that you made or somebody made back to you after, say, a telephonic or not even after a telephonic, but it involves a recommendation to the subcommittee meeting or subcommittee input, and Sheila just said that the DFO or ADFO should be copied on that recommendations.

DR. BEEMAN: That's what I was going to say, why don't we just have them permanently copied on things so that way you'll know and

you're in the loop and --

CHAIR LEINENKUGEL: So can you put that down on that one-pager that I asked for? So there's a couple of one-pagers. There's the contact list of all of us with personal email, if that will work for everybody, and/or a work email if you want to use your VA, and then I would say the personal cell phone.

DR. BEEMAN: Could have used that last night.

(Simultaneous speaking.)

CHAIR LEINENKUGEL: So keep it simple.

MS. HICKMAN: We got it.

CHAIR LEINENKUGEL: Then the one-pager on rules that we just discussed. That would be very helpful as a reminder for each one of the subcommittees. So with that said, I think we're off of this page.

Decision-making, voting protocol. Okay. Let's spend some time here. The Chair and DFO are encouraged to generate a robust

discussion -- why I'm reading this is because, believe it or not, I haven't read this page yet -- a robust discussion about the matter at issue before any voting takes place. Well, done, absolutely. That's a given.

The Chair or DFO should solicit the views of all commissioners so that any comment, insight, or concern that could influence a commissioner's conclusion on the matter at issue is heard and considered before a vote related to that. That's just good protocol. That's standard procedure.

When presenting a question for a vote, the Chair or DFO should solicit and answer a question about its meaning before the vote begins. I think from what I've witnessed here at this group, we're going to ask every question before anything comes to a vote.

Voting should be done simultaneously. The objective is to avoid any potential order bias associated with sequential -- oh geez who wrote this a lawyer?

(Laughter.)

CHAIR LEINENKUGEL: Voting should be done simultaneously. The objective is to avoid any potential order biases associated with sequential voting, and thereby enhance the integrity and meaning of the voting results. Interpret that for us.

MS. ENGILES: You want me to say what that means? You don't have, you know, if you're voting on something and then maybe there's not a couple of commissioners present, so then the next day they hand in their vote. Whoever is here, as long as we have a quorum, those are the people who vote. Whatever their decision is, it's good. We don't have, like, a follow-up vote on that. I pulled that from the lawyerspeak and I should have simplified.

(Simultaneous speaking.)

DR. JONAS: Tom, Shira, and Jake, you all said yes --

MS. DICKSON: Yes, you're holding back on your vote to wait to see what somebody

else does first. That's what it means to do, you know. Everybody make their own decision and not do that just because Shira said yes.

(Simultaneous speaking.)

CHAIR LEINENKUGEL: Okay. That's as clear as mud.

(Simultaneous speaking.)

MR. ROSE: As far as protocol, how do you do it? I mean, is there a motion to approve this, a second, and then any discussion --

CHAIR LEINENKUGEL: That's exactly what I will do, yes. There will always be a motion that should be brought up, and there should also be approval and seconded, and then there should be discussion. The names of the committee members and their respective votes should be read aloud, otherwise it will be hard to vote, yes, absolutely.

The question put to the vote should not be the subject of further discussion or clarification while the voting is underway.

Yes, understood.

Briefing materials provided to commissioners as background materials before a meeting should be thorough and, to the extent possible, include the questions that will be voted upon. Yes. The objective is to maximize the meeting and utility of the voting results by ensuring that the commissioners have had ample opportunity to study background materials before the day of the meeting. Yes.

DR. JONAS: What does before mean?

CHAIR LEINENKUGEL: It could be the day before.

DR. JONAS: The day before. Okay.

(Simultaneous speaking.)

CHAIR LEINENKUGEL: Again, I think it's good to go over this because it's going to be happening, and then we have the DFO and the group behind us to make sure that all the rules are being abided by, either by the rules of the FACA and it could also be by the rules of good protocol and order.

We're not quite to this page yet because we're going to leave that one there as an incentive. It's an incentive so that we get down to what Tom and I need to discuss with all of you, and I think Tom has already started it, at least with Shira and with Wayne. We want to go back to Tab F.

Tom, do you want to start? I don't think we -- yeah, I would just like you to start and then let's discuss this.

DR. BEEMAN: Okay.

CHAIR LEINENKUGEL: With your number one, examine the efficacy of the evidence-based therapy model.

DR. BEEMAN: We learned about that. Today we learned about how they come up with evidence-based protocols, and we talked a little bit about the scientific model and maybe some of the impediments that gives us when we're talking about complementary therapies because it's almost like they're antithetical to each other. We have to figure out a way to

sort of evaluate that, and then I think make recommendations around how do we think through that, and I think we got a good overview from Dr. Murphy on that today.

And then number two is really conducting the survey, and I think we learned a lot about the questions that are already answered but we also know that there's a lot that are not answered yet. And so one of the things we want to do is -- I should be using this I guess. I apologize. One of the things I think we need to do is determine how much of the material is already, are 80 percent of it already out there that we can just aggregate the data? And then we have to make a determination whether or not we have to ask for a waiver so that we can actually collect the data and, if so, how do we want to do that, in a quantitative way or a qualitative way? And I think we're going to have to sort of defer to the expertise to say, you know, how long would that take, does that make sense for us, and we

might have to be doing two things at one time: collecting all the data that's already extant, at the same time putting in a waiver request, and then, thirdly, thinking through whether or not it should be qualitative or quantitative. And I think I'd be turning to Dr. Murphy and her team on that.

Any questions or suggestions from anybody on that? Are we heading in the right direction?

And number three, why I really wanted to have some clinical people is a lot of these treatments are already being done, you know. We had a discussion about what's happening at NICoE, but it's happening across the country. And, you know, we wanted to see, you know, what the research is for equine therapy, you know, what's been documented in the record. I know that we're going to have some research done on that, the research of the research, and then really evaluate. And we have, you know, two researchers as part of the

team to say, you know, this makes sense, I mean, it passes the test for authentic research or this is kind of not so authentic.

And I think what we're also probably going to do is talk about some other complementary therapies. We talked about the use of cannabis, but there's probably a couple of other ones that are not included in here that, you know, like tai chi.

I'll tell you an anecdote that's kind of fun. I have an 80-year-old Catholic sister who's our best friend of our family. She teaches tai chi to poor African-American kids in Chester, and they've documented how much more attentive and how much better their schoolwork is going because they're calmer. And she's teaching the kids how to teach their parents when they go home.

So, you know, there's stuff that's happening all over the country that's, you know, maybe not well documented, but, you know, certainly seems to have some efficacy. And we

should see what's out there in the literature and see if, you know, that's just part of an overall -- and I think, from my perspective, is what we're trying to do is give the physicians and care providers a group of alternatives and complementary procedures that they can use and rely that this can help them in their armamentarium but not everyone might help every single person.

I mentioned my attention span on yoga, although I'm doing better. I wanted to add for the record, but since we're now on the record, is that I wanted the surgery just because I didn't want to improve my wife was right, but I proved that she was.

CHAIR LEINENKUGEL: Appreciate it. Thanks, Tom. And I have four and five, so it's study the sufficiency of the resources of the Department to ensure that the delivery of quality care for mental health issues among Veterans seeking treatment within the Department. This one is interesting because it

always goes back to when I look at resources it's always dollars. It's money available. And that's not always the case. It isn't in this. It's what you heard me ask yesterday that we need to have Dr. Carroll and Dr. Stone get back to us on.

And resources are also people. We need to diffuse and have the VA, and this commission can be something that I believe is the conduit for answering a question or answering the mail that's been left unanswered for 18 months. How many clinicians are we truly short, and what does short mean? I mean, there is a TO. Us military people know a table of organization. And then there is what's called the combat TO that you -- TO is what your desk world environment is, but then you have what marines would call combat. That's really who you're going to take to battle, and it might be 50 people less per battalion. Matt and Jamil, you know that. You're always a little short, but you somehow make up with

attachments and stuff.

So, I mean, that has to be answered because the term in number that's been used and bantered for 18 months is counterproductive for the VA at this point and it's being misused. And I think we are mismanaging it as the VA. And I've had a side conversation already with the acting secretary. He's well aware of this. And I think that they have been waiting for somebody like Dr. Stone to come in, along with now Dave Carroll and his group, being put on notice to come up with some precise numbers for us because dollars are certainly not the issue. I mean, come on. There's 70-plus billion dollars that are out there for VHA usage.

And the other thing I would like this group to look at and explore at some point is, when it says sufficiency, I also look at that as being are we effectively utilizing the dollars and resources? And, again, I'm going to use, just my own opinion is that we are not and it's the number of programs that are

currently being explored within the VA right now by a group of folks that have never been looked at before. And I can tell you the number that I was given was over a thousand programs, and maybe 900 of them are obsolete or are inconclusive or are unfunded and never-ending. I don't know the answer to that. I mean, these are all hypotheticals, but there are some easy numbers that were looked into over the last three weeks and they're nowhere near completion yet. But I would think and know this incoming secretary is going to be very adamant about getting to, you know, right-sizing and what we refer to as re-purposing dollars towards true Veteran care.

So that's why I think four is really important for us to take a leadership role in maybe providing that some of that early guidance and recommendations, and that's why this would not necessarily just be an end of the study report-out 18 months from now. This could very well be one of these ongoing rhythms

that we start as a commission that we would probably and should vote upon. Maybe it's next meeting. Do we start reporting out some of our findings not only to SVAC and HVAC, which is called for in the legislation, but do we do it directly with a phone call along with, under FACA rules, the DFO or ADFO about some of the early findings or early recommendations that we have. And I think that that would be, I don't know if it's a first for a commission to do that, but I think it's something to explore and, at least for us, to noodle over until we come back in the month of August.

So five is another one of the current treatment resources available within the Department to assess. There's a lot of commonality. I looked at at the end of this with what, Tom, you have with three that I gave over to you. So, I mean, whoever wrote it tells me that they did it for a reason, right? They wanted to end with making sure that the efforts of the Department to expand

complementary and integrative health treatments viable to the recovery of Veterans, which is really what the act is, COVER, expedited recovery of Veterans, with mental illness issues as determined by the secretary to improve the effectiveness of treatments offered by the Department.

So it's really taking a look at diagnosing the VHA structure currently as-is. Are we doing it robustly? Are we doing it with 50 percent effort? We need to call out some of these things.

But the other ones are just numbers and percentages, and these are the other ones that I think are just as hard as some of the surveys. So, again, it goes back to surveying and then trying to get the right numbers.

Now, these are numbers, in my opinion, that DHA should own, because it's all interdepartmental. It's not the Veterans that are going out to private care, and it's not the Veterans that are not receiving care. These

are the ones that are currently receiving care. So, again, I would lean on Rick Stone, Dave Carroll, and current group.

But remember I also said I don't always trust the VA numbers. I said that early on in yesterday's meeting. And so I may ask you to have a vote or I may ask the DFO, depending on the protocol, to have an outside consultant group after we discuss it and vote on it to possibly come in to take a look at that just to fact check. And I'm up in the air about it at this point. I've made no decision whatsoever. It's a washout because, again, I've seen numbers that totally conflict with what reality is, and some of their numbers are spot-on. But it's just, once you lose that trust factor, it's hard to regain.

So I want to make sure that we're giving the best effort as the COVER Commission back to the people that wrote the legislation and to the group of Veterans that we're going to actually expedite their recovery. And the

key is expedite recovery. And so I think that we need to always keep that in mind.

So, again, I will work on this over the next couple of weeks as far as naming some people or looking at some people. And Tom and I will work that conversation before we come with recommendations or finalizing it with a DFO and ADFO. Does that make sense, Tom? Is the rest of the Commission comfortable with that? Good.

And, again, it would be nice to have some clinicians, you know, on that. But I will leave both available for you for number three. I think there's going to be a lot of subject matter experts and also the finance people have changed at VA, and the VHA finance people have changed, as well. So they're looking at things differently than the past. That's just normal practices.

DR. MAGUEN: I was going to say I'd also make some recommendations for some of the suicide people who are also clinicians and sort

of have national roles, as well? So for that number four, yeah.

CHAIR LEINENKUGEL: Yeah.

DR. MAGUEN: Sorry. For five. So, yes, so I think that that will be important because it's interesting that it's specifically focused on suicides in particular for number five.

So the other thing that I was going to say I'm going to on Friday an all-day training on suicide that is an update for clinicians. And so I can also report back our next meeting just so everyone is aware of what the latest is.

CHAIR LEINENKUGEL: Yes, that would be great and very helpful and we would expect that. So thank you for offering that. And it's timely, as well.

DR. MAGUEN: Yes, exactly. So --

CHAIR LEINENKUGEL: Also remember, and I think you all got this, why Drew Trojanowski is in as an advisor from the White

House, this is a White House initiative that hopefully is going to be completed since the President signed off on it in January, the VA was supposed to have the plan ready by March and the plan was not ready until last month. And so this guy has been, as Matt knows, under the gun to complete this in a real short amount of time.

And the basis of the EO now between DoD and VA is very, very good from where it was four months ago. And I think that having Wilkie coming underneath Mattis and getting Mattis's team re-energized for what I call two VA-DoD collaboration, and you got to remember this is game-changing because what the EO is calling for for the first time ever, the biggest part of it is those Veterans that are leaving the service are going to automatically be pre-enrolled, I use that loosely, into the VA system. So whether it's the TAP process or whatever, Joe and Suzie departing the Army are going back, one to Minneapolis and one to

Salem, they're both going to have a home record established with already where to go to the VA in Salem and Minneapolis and for the following year, regardless of what their rating is for the VA, they are going to receive mental healthcare at any point in time during that first year. So, I mean, that's game-changing.

Trust me, as we all know that have worked in government, it sure sounds good. It's going to be really difficult going through just the pre-enrollment process now and then getting Johnny and Susie fully onboard because, let's face it, a lot of them are the 23- and 24-year-olds, the only thing on their mind is to get home. And, you know, now we have to really what I call sell and market this executive order, thus that is why this will be a big public initiative, whether it's at the White House South Lawn or East Lawn, it doesn't matter, but it will be a big announcement. And also DoD is, for the first time, supposed to play big in the field of you are leaving the

service, thank you very much, rather than, Matt and my days and probably Tom's days of, hey, we don't really want you to leave yet, we want you to go see, you know, you're going to get a command next, why don't you think about that, or what did we call those guys, the gunnery sergeants for the enlisted guys? It's been 40 years. No, no, it was the person that would try and re-enlist. There's a term for that person, but you always tried to grab them before they exited. And then once they told you they weren't going to re-enlist or take the command, it was get out of here.

So that's what's coming. So by the time we're meeting in August, I think you're going to see and hear a lot more probably, hopefully from Drew, unless he's just running around trying to do things, but also you should be made aware Matt and the Bush Heritage Foundation has been very active and proactive in working with Drew, as have some other what I call subcommittee groups, subject matter

experts, in helping draw all of this together. So it's not just VA-DoD collaborating, it's groups like Matt with the Bush Foundation or the Heritage Foundation and certainly others that have come together and said we know how to do this, we know where the trapdoors are, and we know where the barriers are, and let's help you. And they've been a huge help in a short amount of time.

DR. MAGUEN: Can I ask a quick question about that critical bridge that you just talked about between the DoD and the VA? Is the EO saying that if you screen positive then you're automatically enrolled, or is it going to include if you just finish service you're automatically enrolled?

CHAIR LEINENKUGEL: The latter.

DR. MAGUEN: Oh, that's fantastic. Okay. So, yes, so it will capture everyone. So, basically, we will now be able to track all Veterans, which is unbelievable.

CHAIR LEINENKUGEL: You are correct.

DR. MAGUEN: Amazing.

CHAIR LEINENKUGEL: And this came from the State of Arizona. And if you look at the Arizona coalition and what they've done, I reiterated that a couple of times yesterday, it was the most fascinating thing that I've seen because there are three outstanding leaders that lead that process and don't take no for an answer. I know them personally. Drew was the one that introduced them to me over a year ago. I went to one of their coalition with Veterans. You heard me talk about the story of the traumatized Veteran lady. She was from that group from Phoenix. It was that VA.

So, I mean, this is game-changing stuff that we're involved in. So on top of it, I only say that because there's an intersection with suicides with the mental health, and there's a huge intersection, and that's why Drew wanted to be part as an advisor of the COVER Commission. And I absolutely said yes and called Sheila, just so you have full